Provider *Insider*

Alabama Medicaid Bulletin **May 2005**

The checkwrite schedule is as follows:

5/06/05 5/20/05 6/03/05 6/17/05 7/08/05 7/22/05

As always, the release of direct deposits and checks depends on the availability of funds.

More Drugs Added to the Electronic Prior Authorization System

Effective April 21, 2005, the Alabama Medicaid Agency implemented the second phase of drugs to the electronic prior authorization (PA) system. The drug classes included in the second implementation phase are as follows:

ADHD Agents
Antidepressants
Antihyperlipidemics
Alzheimers Agents
Diabetic Agents

There will be no change in the way a pharmacist submits a claim. Medicaid's system will check claims history to determine if PA medical requirements are met. If it is determined that all criteria are met and request is approved, the claim will pay and no manual PA request will be required. If approval cannot be determined based on available claims history, a manual PA request will be needed. Here is how it works:

Example A:

A pharmacist submits a claim for an antihyperlipidemic. The patient has tried and failed on two prior therapies that were billed and paid by Medicaid and has had a medical claim filed with an appropriate diagnosis. The system will identify these claims and match them with the clinical criteria. If all criteria are met as in this example, the claim will pay automatically and no manual PA will need to be obtained.

(Continued on Page 3)

In This Issue…

Pass It On!

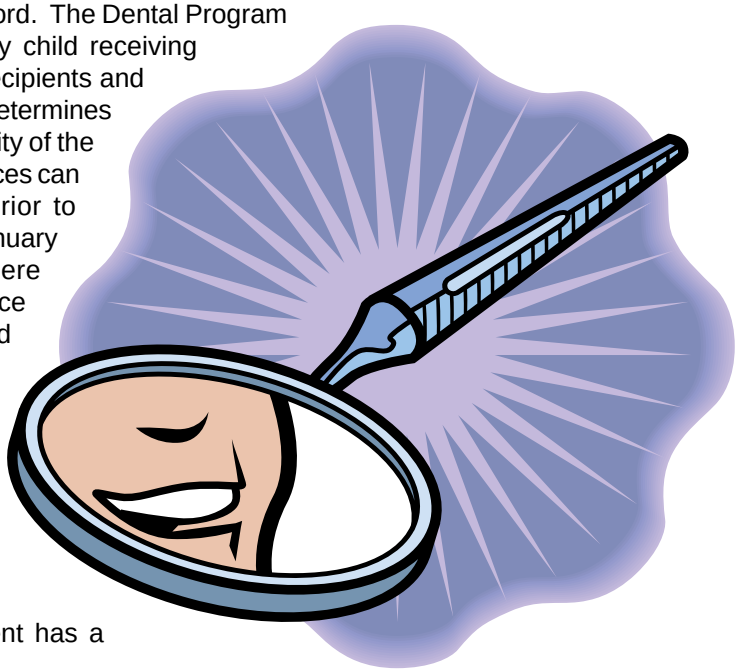
Everyone needs to know the latest about Medicaid.

Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Dept.*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other _____*

Clarification on the Dental Program for Prior Authorization

For claims processed on or after April 9, 2005, the Dental Program is lowering the age to five years old for prior authorization of hospital cases. This change was coordinated with the Dental Task Force with input from professional dental associations and the UAB School of Dentistry. Medicaid currently requires that providers who perform services in a hospital setting document the information below in the patient's record. The Dental Program will be auditing a percentage of provider records for any child receiving dental services in a hospital setting. This will include **all** recipients and not just those who require a prior authorization. If the audit determines that the documentation is not sufficient to prove the necessity of the procedures being performed in the hospital setting, the services can be recouped or subsequent claims can be reviewed prior to payment. The information below has been printed in the January Provider Insider and the January Provider Manual. There continue to be errors in billing of the incorrect place of service for these cases. These instances when found will be referred to the Provider Review Unit and further action will be taken. If you have questions, you can call the Dental Program at 334-242-5472 or 334-353-5959.



The policy is as follows:

For prior authorization for patients **FIVE** years through 20 years of age, at least one of the following criteria justifying use of general anesthesia in the hospital must be met:

1. Child or adolescent who requires dental treatment has a physical or mentally compromising condition
2. Patient has extensive orofacial and dental trauma
3. Procedure is of sufficient complexity or scope to necessitate hospitalization
4. Child who requires dental treatment is extremely uncooperative due to acute situational anxiety, attention deficit disorder, or emotional disorder

   (See requirement for additional supporting docomentation in a. through k. below)

Approval is typically given for a specified time frame not to exceed six months. Treatment must be dentally necessary and supported by a treatment plan and appropriate radiographs. Requests for treatment in a hospital setting based on lack of cooperation, anxiety, attention deficit disorder, or emotional disorder are not typically approved when the dental history shows treatment was rendered in the office in the past.

Documentation from the medical record justifying one or more of the above four criteria is required to be submitted with the Prior Authorization request along with a completed Informed Consent. On children ages 3 through 4, documentation in the record will be required to support the necessity of the treatment performed in a hospital setting. Criteria number 4 only (without a physical or mental disability) further requires a report of at least one active failed attempt to treat in the office. This report must include:

a. Recipient's behavior preoperatively
b. Type(s) of behavior management techniques used that are approved by the American Academy of Pediatric Dentistry
c. Recipient's behavior during the procedure
d. The use, amount, and type of local anesthetic agent
e. Use and dosage of premedication if attempted
f. Use and dosage (%, flow rate and duration) of nitrous oxide analgesia used
g. Procedure(s) attempted
h. Reason for failed attempt
i. Start and end times of the procedure(s) attempted
j. Name(s) of dental assistant(s) present in the treatment room
k. Presence or absence of parents or guardians in the treatment room

If requirements d, e, or f above were attempted but not successfully accomplished, the report must state the reason(s) for not carrying out or accomplishing these requirements.

More Drugs Added to the Electronic Prior Authorization System *(Continued from Page 1)*

Example B:

A pharmacist submits a claim for a diabetic agent. The patient has tried and failed on two prior therapies that were billed and paid by Medicaid but has no medical claim on file that lists an appropriate diagnosis. The system will send an "On-Line PA Denied" message to the pharmacist. The pharmacy/ physician must then initiate a manual PA request. An online PA denial does not mean that the service requested is a non-covered service; only non-covered services can be charged to the recipient. To determine if a service that has received an online PA denial is covered, a manual PA request **must** be completed. Only after the manual PA request is denied, can the pharmacist charge the recipient.

Some possible reasons for an electronic denial:

1. Patient does not meet clinical criteria based on available claims history
2. Units dispensed are over 100% of the maximum quantity limits
3. Previous PA issued and still in effect with a different NDC
4. Recipient is a new Medicaid eligible and no claims history exists

Please direct policy questions to the Medicaid office at (334) 242-5050. Questions concerning prior authorization denials/approvals should be directed to Health Information Designs, Inc. at 1-800-748-0130.

Procedure Code Correction for New Operating Microscope Policy

Please note the corrected procedure codes in this article. In keeping with Medicare's policy, effective January 1, 2005, the use of an operating microscope (code 69990) may be paid separately only when submitted with the following CPT codes: 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898, 64905-64907. Changes will be included in the next Provider Manual update in Chapter 28, Physician's.

Certification Needed

Durable Medical Equipment Providers of Motorized/Power Wheelchairs must have at least one employee with certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) or registered with the National Registry of Rehab Technology Suppliers (NRRTS). Suppliers must meet these certification requirements to provide Motorized/Power Wheelchairs.

If you have any questions, please call Ida Gray at 334-293-5577.

Patient 1st Information

Effective April 1, 2005 the referral requirement for Patient 1st recipients has been reinstated. Medicaid will not cover services which require a PMP referral without the issuance of the referral by the PMP.

Verify Patient 1st eligibility for all Medicaid recipients. If it is determined that a Medicaid recipient is on the Patient 1st Program PLEASE submit the Patient 1st referral form with all prior authorization requests.

Patient 1st Providers, please remember it is important to obtain the recipient's consent before submitting a PMP change form (Form 349).

G-Codes for PET Have Changed

Effective April 1, 2005, CMS deleted G-codes for PET scans and cross walked the G codes to CPT codes. Effective with the date of service July 1, 2005, Medicaid will no longer accept G-codes for PET scans. Providers may bill either the G-code or CPT code up until July 1, 2005. The CPT codes replacing the G-codes for PET scans have an effective date of April 1, 2005, For questions, contact Leigh Ann Payne at 334-353-5263.

www.medicaid.state.al.us

Notice for EPSDT Providers

Preventive health services are only available to eligible children under 21 years of age. Preventive health services are well child check-ups (EPSDT screenings) and immunizations. Well child check-up services are reimbursable if the provider has signed an agreement with Medicaid to participate in the screening program. The administration fee for immunizations designated as VFC are reimbursable if the provider has signed an agreement with the Vaccines For Children Program administered by the Department of Public Health. Annual routine physical exams are not covered for eligible recipients 21 years of age and older.

The only preventive health services the Agency reimburses for are for well child check-ups (EPSDT screenings) and immunizations. Annual routine physical exams are not covered.

Visit Alabama Medicaid

ONLINE

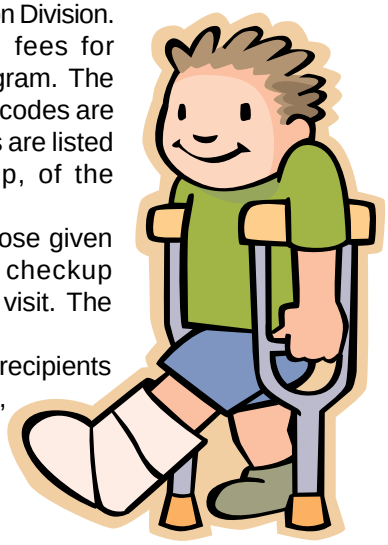
www.medicaid.state.al.us

Providers can :

- **Print Forms and Enrollment Applications**
- **Download Helpful Software**
- **Obtain Current Medicaid Press Releases and Bulletins**
- **Obtain Billing and Provider Manuals and Other General Information about Medicaid**

Vaccine For Children (VFC) Program and Administration Fee(s)

Vaccines are provided at no charge to enrolled VFC providers through the Department of Public Health, Immunization Division. Medicaid reimburses administration fees for vaccines provided through the VFC Program. The VFC Program designates which CPT-4 codes are used in the VFC Program. These codes are listed in Appendix A, Well Child Check-Up, of the Provider Manual.



Medicaid will reimburse for each dose given even when billed with a well-child checkup (EPSDT screening) or a physician office visit. The rate for an administration fee is $8.00.

Please note the VFC Program is for recipients 18 years of age and younger. In addition, participation in Medicaid is not required for VFC enrollment. Participation in the VFC Program is not required for Medicaid enrollment.

Vaccine For Children (VFC) CPT-4 Codes

The Vaccines For Children Program updated the list below as of March 3, 2005

90647	Haemophilus influenzae type b (Pedvax)
90648	Haemophilus influenzae type b (ActHib)
90655	Influenza, preservative-free (6-35 months)
90656	Influenza, preservative-free (3 years and older)
90657	Influenza (6-35 months)
90658	Influenza (3 years and older)
90669	Pneumococcal Conjugate 7 valent (PCV)
90700	Diphtheria, Tetanus, Acellular Pertussis (DTaP)
90702	Diphtheria, Tetanus (DT)
90707	Measles, Mumps, Rubella (MMR)
90713	Poliomyelitis (IPV)
90714	Tetanus, Diphtheria (Td), preservative-free
90716	Varicella (Chickenpox)
90718	Tetanus, Diphtheria (Td)
90721	Diphtheria, Tetanus, Acellular Pertussis and Haemophilus influenzae type b (DTaP-Hib)
90723	Diphtheria, Tetanus, Acellular Pertussis, Hepatitis B, and Poliomyelitis (DTaP-Hep B-IPV)
90732	Pneumococcal Polysaccharide 23 valent (PPV)
90733	Meningococcal Polysaccharide (MPSV4), (2-18 yr of age)
90734	Meningococcal Conjugate (MCV4), (11-18 yr of age)
90744	Hepatitis B (Hep B)
90748	Hepatitis B and Haemophilus influenzae type b (Hep B-Hib)

These CPT codes should be used ONLY when billing Medicaid for the $8.00 administration fees (for each immunization administered) for vaccines received through the VFC Program. To enroll with the VFC Program, please contact the Department of Public Health, Immunization Division at 1-800-469-4599.

Visit Medicaid online at www.medicaid.state.al.us

Review of Allergy Treatments

Physicians may bill for antigen services using only the component codes (i.e., the injection only codes 95115 or 95117) and/or the codes representing antigens and their preparation (i.e., codes 95144 through 95170). Physicians providing only an injection service must bill for only code 95115 or code 95117. Professional services for allergen immunotherapy multiple injections (procedure codes 95117 and 95125) should be billed using only one unit. The Agency will deny claims for these procedure codes when more than one unit is billed.

Physicians providing only the antigen/antigen preparation service should bill the appropriate code in the range of 95144 through 95170. Physicians providing both services should bill for both services. This includes allergists who provide both services through the use of treatment boards.

Procedure codes 95144 - 95170 are used for the provision of single or multi-dose vials of allergenic extract for single patient use only. These procedures should only be billed at the time that these vials are supplied to the patient. The number of units billed should be based on the number of 0.5 ml doses in the vial(s). Multiple vials of the same allergen are not covered for the same date of service. When billing these codes, physicians must specify the number of doses provided. For example, if a multi-dose vial of antigens is prepared (i.e., a vial with 7 doses) and only one dose is injected, then seven doses of antigen and one injection service may be billed. For those remaining doses, only the injection codes may be billed.

Dentists Using Oral Cavity Designation Codes

With the implementation of HIPAA in October 2003, dental providers began using the new oral cavity designation codes. These codes can be found in the Medicaid Provider Manual Chapter 13. We continue to see providers using the old values of UL upper left, UR upper right, etc. These values are not recognizable and are being denied. If you are using Provider Electronic Solutions (PES), do not bill more than one of the values per detail line. If you have questions regarding these values, you can call Tina Edwards at 334-242-5472.

Dental Providers and Hospitals

Effective April 9, recipients age 5 through 20 require prior authorization for dental procedures performed in the hospital setting. For details on the criteria, look in Chapter 13-8 of the Medicaid Provider Manual.

Dental Workshop Friday, June 10th

The Dental Program will be offering a 3 hour Medicaid Update at the Alabama Dental Association Annual Meeting (3 CEUs). This will be a fast-paced interactive workshop that is a must attend. For details and registration information, call the Alabama Dental Association at 334-265-1684. There is no cost for dental staff members.

Dental X-rays with Claims

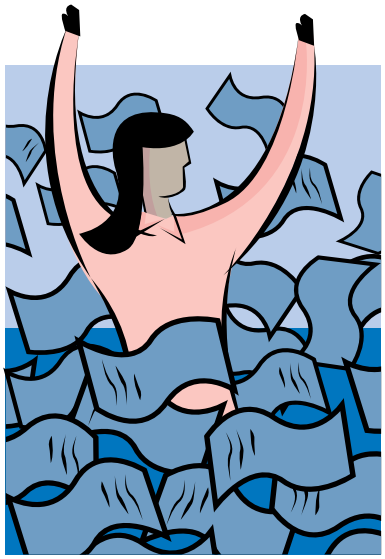
When sending in x-rays with dental claims for override or review by the dentist, please do not mail these claims to EDS. The Dental Program at Medicaid has the staff that process these requests. Medicaid is not responsible for x-rays lost due to incorrect mailing to EDS. The correct address is: Dental Program, Alabama Medicaid Agency, PO Box 5624, Montgomery, AL 36103-5624.

www.medicaid.state.al.us

Seasonale Max Unit Override Clarification

Seasonale is an oral contraceptive packaged as a 91 (three month) day supply. The package labeling instructs providers not to break the package; therefore the package should be dispensed in full. In response to inappropriate billing, max units on Seasonale have been set at zero. One unit of Seasonale will be allowed per three months; an override must be obtained with each claim.

Attention Hospice Providers



Beginning, April 1, 2005 all Hospice providers must complete the Medicaid Hospice Election and Physician's Certification, Form 165 to certify Medicaid recipients for the hospice program. The Medicaid Hospice Election Form 165 should be completed for recipients with dual eligibility (with Medicare part A) upon entry into a nursing facility. The Medicaid Agency will recognize the Medicare election form as election for both Medicare and Medicaid for dually eligible (with Medicare part A) recipients receiving hospice services in the community. Chapter 51 of the Alabama Medicaid Agency Administrative code states "If an individual meets the eligibility requirements for hospice care he or she must file an election certification statement with a particular hospice". The Administrative Code also states "If an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs. Language contained in the Administrative Code, as well as Chapter 18 of the Medicaid Provider Manual, refer to the election certification statement but does not specify the use of the Medicaid election form. Revisions to these documents to include this requirement are in progress. The Medicaid election form is available on the agency website at www.medicaid.state.al.us.

If you have any additional questions or need further clarification, please contact Wanda Davis, at (334) 242-5018.

Important Mailing Addresses	
All Claim forms, Consent forms, and other mail	EDS Post Office Box 244032 Montgomery, AL 36124-4032
Inquiries, Provider Enrollment Information, and Provider Relations	EDS Post Office Box 241685 Montgomery, AL 36124-1685
Adjustments	EDS Post Office Box 241684 Montgomery, AL 36124-1684

EDS Provider Representatives

G R O U P 1

North: Jenny Homler, Karen Hutto, and Lisa Hodge

Bibb, Blount, Calhoun, Cherokee, Chilton, Clay, Cleburne, Colbert, Coosa, Cullman, DeKalb, Etowah, Fayette, Franklin, Greene, Hale, Jackson, Jefferson, Lamar, Lawrence, Lauderdale, Limestone, Madison, Marion, Marshall, Morgan, Pickens, Randolph, Shelby, St. Clair, Talladega, Tuscaloosa, Walker, Winston

lisa.hodge
@alxix.slg.eds.com
334-215-4159

jenny.homler
@eds.com
334-215-4142

karen.hutto
@alxix.slg.eds.com
334-215-4113

South: Melanie Waybright and Denise Shepherd

Autauga, Baldwin, Barbour, Bullock, Butler, Chambers, Choctaw, Clarke, Coffee, Conecuh, Covington, Crenshaw, Dale, Dallas, Elmore, Escambia, Geneva, Henry, Houston, Lee, Lowndes, Macon, Marengo, Mobile, Monroe, Montgomery, Perry, Pike, Russell, Sumter, Tallapoosa, Washington, Wilcox

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology

melanie.waybright
@alxix.slg.eds.com
334-215-4155

denise.hooker
@alxix.slg.eds.com
334-215-4132

CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

G R O U P 2

Rehabilitation Services
Home Bound Waiver
Therapy Services
(OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

tracy.ingram
@alxix.slg.eds.com
334-215-4158

laquita.wright
@alxix.slg.eds.com
334-215-4199

Public Health
Elderly and Disabled Waiver
Home and Community
Based Services
EPSDT
Family Planning
Prenatal
Preventive Education
Rural Health Clinic
Commission on Aging
DME
Nurse Midwives

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home

ann.miller
@alxix.slg.eds.com
334-215-4156

shermeria.hardy
@alxix.slg.eds.com
334-215-4160

Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

State Fiscal Year 2004-2005 Checkwrite Schedule

05/06/05	07/22/05
05/20/05	08/05/05
06/03/05	08/19/05
06/17/05	09/02/05
07/08/05	09/09/05

Alabama Medicaid Bulletin

Post Office Box 244032
Montgomery, AL 36124-4032